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Report to the Chairman, Committee on Ways and Means, House of Representatives

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MEDICARE CATASTROPHIC ACT

Options for Changing Financing and Benefits

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Human Resources Division

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September 15, 1989

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

On July 27, 1989, you asked us to review the Medicare Catastrophic Coverage Act of 1988 (MCCA, Public Law 100-360) and provide a summary of the options available to either (1) revise the benefits and financing under the act or (2) phase out the program. Concern about the act has been expressed by members of Congress and the public, particularly regarding the amount of supplemental premium that higher income Medicare beneficiaries will pay.

This report presents options relating to reducing the amount of MCCA funding coming from beneficiary premiums through financing the program with other sources of revenue, reducing benefits, redistributing the cost of the program among beneficiaries, and various combinations of these alternatives. In summary, there are no painless ways to reduce beneficiary funding. Revenues from other sources need to be raised or benefits provided under MCCA need to be cut. Compounding the problem from a budget deficit standpoint is the fact that MCCA was designed to build a contingency reserve so that estimated revenues exceed estimated costs for the catastrophic program in its early years. Therefore, repeal of the program would increase the federal deficit for Gramm-Rudman-Hollings (Public Law 100-119) deficit reduction purposes for the next few years.

Benefits and Funding Under MCCA

Medicare, authorized by title XVIII of the Social Security Act, offers a broad health insurance program to eligible individuals—almost all people 65 years old or older and some disabled persons. Benefits are provided under two parts. Part A, hospital insurance, covers inpatient hospital, skilled nursing facility, home health, and hospice services. It is financed primarily by a 1.45-percent Social Security payroll tax paid by employees and by employers—the hospital insurance tax. People most often become eligible for part A when they become 65 years old and they or their spouses have worked for at least 40 quarters in jobs subject to Social Security payroll taxes.

Part B, supplementary medical insurance, covers physician services and a broad range of other services furnished on an outpatient basis, such as

laboratory and X-ray services and medical equipment used in the home. All Americans 65 or older and any other person who is eligible for part A are eligible for part B. People electing part B coverage pay 25 percent of its costs through monthly premiums, and the government funds the other 75 percent from general federal revenues. In 1989, the taxpayer subsidy for part B is an estimated $1,004 per enrolled beneficiary.

MCCA was signed into law in July 1988. The act authorized substantial increased protection for beneficiaries who incur large health care expenses by limiting the amount of out-of-pocket costs for Medicare covered services. MCCA also authorized several new benefits and expanded the extent of services covered for several other benefits.

Part A of Medicare was designed to be funded primarily as social insurance; that is, people pay for the program while they are working and reap the benefits when they are retired or become disabled. In effect, part B of Medicare offers beneficiaries a heavily subsidized insurance policy; beneficiary premiums cover only 25 percent of the program's total cost. In contrast, MCCA is designed to be self-funding with Medicare-eligible beneficiaries paying all of the increased Medicare costs resulting from the act.

To obtain the necessary funds, three new types of premiums are included in MCCA. The first of these is referred to as the catastrophic coverage premium and is paid by all beneficiaries. MCCA set the amount of the catastrophic premium at $4.00 per month in 1989; this will increase each year to $7.18 per month in 1993. For subsequent years, MCCA provides that the catastrophic coverage premium will be adjusted to reflect the rate of change in catastrophic costs in previous years and whether the premiums in prior years were too high or too low with respect to actual costs.[1]

The second new premium required of all Medicare beneficiaries is called the prescription drug premium, which will begin in 1991 at $1.94 per month rising to $3.02 per month in 1993. After that time, the drug premium will be adjusted annually in a manner similar to that used for the

[1]The actual formula for computing the catastrophic coverage premium monthly amount is quite complicated with a number of special adjustments depending on changes in the consumer price index and the extent of the surplus or deficit in catastrophic outlays in preceding years. See section 1839 (g)(2) of the Social Security Act for details.

catastrophic coverage premium.[2] Table 1 lists the monthly amounts for the catastrophic coverage and drug premiums for 1989 through 1993.[3]

Table 1: Monthly Amounts of Catastrophic Coverage and Prescription Drug Premiums, 1989-93

Year	Catastrophic coverage premium per month	Prescription drug premium per month	Total paid by beneficiary per month
1989	$4.00	$0	$4.00
1990	4.90	0	4.90
1991	5.46	1.94	7.40
1992	6.75	2.45	9.20
1993	7.18	3.02	10.20

The third new premium is related to the beneficiary's income and is called the supplemental Medicare premium. The amount of the supplemental premium is dependent upon the federal income tax liability of the beneficiary. Beneficiaries who have a tax liability in a year of less than $150 pay no supplemental premium. It is estimated that about 60 percent of beneficiaries will not pay supplemental premiums because their tax liability is below this threshold. The remaining 40 percent of beneficiaries will pay a supplemental premium for 1989 equal to $22.50 for each multiple of $150 in income tax liability up to a maximum amount of $800 ($1,600 for a husband and wife who are both eligible for Medicare). These amounts increase each year, and in 1993 they will equal $42 per $150 in tax liability up to a maximum of $1,050 ($2,100 for a couple). It is estimated that about 6 percent of beneficiaries will pay the maximum amount. After 1993, the maximum supplemental premium will be increased by the percentage, if any, by which part B costs increased more than part B premiums in prior years.

The supplemental premium rate per $150 of income tax liability after 1993 will neither increase by more than $1.50 annually nor decrease. Within this limitation, the rate will be adjusted annually in the same manner as the catastrophic coverage premium discussed above.[4] Table 2 lists the supplemental premium rate per $150 of income tax liability and the maximum amount of supplemental premium for 1989-93.

[2]See section 1839 (g)(3) for details.

[3]These premiums are additional to the regular part B premium, set at $27.90 per month for 1989.

[4]See section 59B of the Internal Revenue Code of 1986 for details.

Table 2: Supplemental Premium Rates Per $150 in Federal Income Tax Liability and Maximum Amount of Supplemental Premium, 1989-93

Tax year	Supplemental premium rate per $150 of tax liability	Maximum supplemental premium per person
1989	$22.50	$800
1990	37.50	850
1991	39.00	900
1992	40.50	950
1993	42.00	1,050

The following sections compare Medicare benefits before and after MCCA. Hereafter, benefits in effect before MCCA will be referred to as "regular benefits" while those under MCCA will be called "enhanced benefits."

Part A Benefits

All enhanced part A benefits under MCCA were effective January 1, 1989. The Congressional Budget Office's (CBO) July 1989 estimate of the value of these benefits is $1.1 billion for fiscal year 1989 increasing to $2.4 billion in fiscal year 1993.

Inpatient Hospital Services

Before MCCA, the beneficiary was responsible for an inpatient hospital deductible ($560 in 1989) for each new spell of illness.[5] After 60 days in a hospital, the beneficiary was responsible during each of the next 30 days for a copayment equal to one-fourth of the inpatient deductible. If the beneficiary were hospitalized for more than 90 days, he or she could draw on a lifetime reserve of 60 days and would be responsible for a copayment each day equal to one-half of the inpatient deductible. Once lifetime reserve days were exhausted, Medicare would make no payment and the beneficiary would be responsible for all hospital charges. Without MCCA, if a beneficiary were hospitalized for the maximum possible coverage of 150 days in 1989, he or she would have been liable for $21,560 in deductible and coinsurance. Moreover, if a beneficiary had had hospitalizations during more than one spell of illness in a year, multiple deductibles would have applied.

Under MCCA, the maximum liability a beneficiary can incur for covered inpatient hospital services is one inpatient deductible per year. All coinsurance requirements were eliminated as was the limit on days and the possibility of multiple deductibles. In 1989, HCFA figures indicate that about 1 million beneficiaries are expected to benefit from elimination of multiple deductibles, and about 300,000 beneficiaries from elimination

[5] A new spell of illness would have begun when the beneficiary had not been in a hospital or skilled nursing facility for at least 60 consecutive days.

of coinsurance and the day limit. The number of people benefiting from the changes should increase over time as the total number of beneficiaries increases.

Skilled Nursing Facility Services

Before MCCA, beneficiaries were entitled to payments for skilled nursing facility services if they had been hospitalized for at least 3 days and, generally, were admitted to the facility within 30 days of discharge from a hospital. The first 20 days were without cost to the beneficiary, who then paid coinsurance for each of the 21st through the 100th day equal to one-eighth of the inpatient hospital deductible ($70 per day in 1989). After 100 days in a spell of illness, benefits were exhausted. For a 100-day stay in 1989, without MCCA, beneficiaries would have been responsible for coinsurance totaling $5,600.

Under MCCA, beneficiaries pay coinsurance equal to 20 percent of the national average cost of a day of care in a skilled nursing facility ($25.50 in 1989) for each of the first 8 days. Beneficiaries pay nothing further through the expanded limit of 150 days per year. Thus, maximum beneficiary liability in 1989 is $204 for 150 days of care. Beneficiaries with lengths of stay of 20 days or less pay more than under former law ($204 versus nothing) while beneficiaries with lengths of stay over 22 days pay less. In addition, a prior hospitalization is no longer required to qualify for skilled nursing facility services.

Home Health Care Services

Before MCCA, Medicare covered an unlimited number of home health visits at no cost to the beneficiary as long as he or she was homebound and in need of intermittent skilled nursing, physical therapy, or speech therapy services. MCCA more explicitly defined intermittent with the effect that more intensive home care will now be covered.

Hospice Care

Before MCCA, Medicare covered a maximum of 210 days of hospice care. MCCA removed the day limit. A small number of beneficiaries will have additional days of hospice care covered.

Part B Benefits

Enhanced benefits under part B will become effective on January 1, 1990. CBO's July 1989 estimates show the value of these benefits to be about $2 billion in fiscal year 1990 increasing to $4.9 billion in fiscal year 1993.

Physician and Ancillary Services

Before MCCA, the beneficiary was generally responsible for the first $75 in allowed charges (the part B deductible) after which Medicare usually

paid 80 percent of allowed charges for covered services.[6] Under MCCA, once beneficiary cost sharing totals $1,370 in 1990, Medicare will pay 100 percent of allowed charges. Each year after 1990, the limit on beneficiary cost sharing will be adjusted so that 7 percent of beneficiaries will become eligible for the 100 percent of allowed charges benefit. In 1990, an estimated 2.3 million beneficiaries will receive benefits at a total cost of about $1.8 billion while in 1993, about 2.4 million beneficiaries will receive benefits of about $4.3 billion.

Expanded Benefits Under Part B

MCCA added two new benefits expanding ones previously covered by part B. A respite care benefit was added to the home health benefit. Under this benefit, a voluntary care-giver living with a chronically dependent beneficiary can obtain a rest period from these responsibilities for up to 80 hours in the 12-month period following the date the beneficiary exceeds the catastrophic cost sharing limit or prescription drug deductible. This benefit is estimated to cost about $420 million in 1993. The second benefit added coverage of screening mammography to the outpatient X-ray benefit. While Medicare does not cover most types of preventive care, periodic mammograms will be covered beginning January 1, 1990. An estimated 3.1 million beneficiaries will receive covered mammograms in 1993 at a cost of about $150 million.

Prescription Drug Benefits

Before MCCA, Medicare did not cover prescription drugs that could be self-administered unless they were furnished as part of inpatient treatment. MCCA added two drug coverage provisions to Medicare. Beginning January 1, 1990, Medicare will pay for home intravenous (IV) drug therapy services, including all personnel, supplies, and equipment, but not the drugs themselves. A fee schedule will be established by the Department of Health and Human Services (HHS) to pay for therapy services, and the drugs will be covered under the provisions of an outpatient prescription drug program.

The second benefit, covering outpatient prescription drugs, will be phased in from January 1, 1990, to January 1, 1993. Medicare will pay for covered drugs after the beneficiary meets the catastrophic drug deductible, which is set at $550 for 1990, $600 for 1991, and $652 for 1992. After 1992, HHS will set the deductible at a level estimated to result in 16.8 percent of beneficiaries receiving payment for drugs during the year.

[6]Several exceptions to the deductible and coinsurance requirements existed. Major ones include that beneficiary cost sharing does not apply to clinical diagnostic laboratory services or to home health services paid under part B.

In 1990, only drugs approved for home IV therapy and those used in immunosuppressive therapy are covered. The beneficiary will pay 20-percent coinsurance requirement in 1990 and succeeding years on these drugs after meeting the drug deductible.[7]

Beginning January 1, 1991, all other prescription drugs and insulin will be covered. A 50-percent coinsurance requirement applies in 1991, 40-percent in 1992, and 20-percent coinsurance after then. In 1993, an estimated 5.9 million beneficiaries will have payments made for them under the catastrophic drug benefit at a cost to Medicare of about $4.3 billion.

Options Related to Financing Sources

One way to decrease the extent of MCCA funding coming from beneficiaries is by using other revenue sources. To accomplish this in a budget neutral way the Congress would need to raise sufficient revenues from other sources to offset the amount that would otherwise have been collected from beneficiaries.

The following sections describe various alternative funding mechanisms for MCCA. A number of these options are summarized in table I.1.

Use Hospital Insurance Tax to Fund All or Part of MCCA Costs

Some or all of the revenues needed to fund MCCA could be raised by increasing the hospital insurance tax rate. This would, in effect, make selected catastrophic benefits regular part A benefits and result in shifting some or all of the financing burden from beneficiaries to active workers and their employers. If the costs of MCCA funded by higher hospital insurance taxes increased faster than the wages to which the tax applies, using this revenue source would have adverse implications for the long-term health of the part A trust fund. We did not estimate long-term implications.

Under current law, regular part A benefits are funded by the hospital insurance tax. An increase in the hospital insurance tax rate from 1.45 to 1.50 percent would be needed to fund part A catastrophic benefits. This would cost the average worker and his/her employer about $0.25 per week each. This would raise an estimated $2.7 billion in fiscal year 1993, while the estimated cost of the enhanced part A benefits is $2.5 billion. Beneficiary catastrophic coverage and drug premiums and/or

[7]The exception is immunosuppressive drugs used more than 1 year after a transplant in which case a 50-percent coinsurance requirement applies in 1990 and 1991, declining to 40 percent in 1992, and 20 percent thereafter.

supplemental premiums could be reduced by the same amount. This revenue would permit a 33-percent reduction in the supplemental premium. The catastrophic coverage and drug premium could be cut by about 65 percent if this $2.7 billion were used to reduce them.

If all part A and B enhanced benefits were funded by the hospital insurance tax, its rate would need to be increased to 1.60 percent, which would cost the average worker and his/her employer about 75 cents per week each. This increase would raise about $8 billion in 1993 while the estimated cost of parts A and B enhanced benefits is $7.6 billion. Supplemental premiums could be eliminated or catastrophic coverage and drug premiums could be eliminated and supplemental premiums reduced by about 50 percent. Under this option, part B related benefits would, for the first time, be partially funded by the hospital insurance tax.

All catastrophic benefits, including drugs, could be funded by the hospital insurance tax. This would necessitate an increase to 1.70 percent in the hospital insurance tax rate, costing the average worker and his/her employer about $1.50 per week. This would raise about $13.3 billion versus estimated 1993 costs of $12.5 billion. Beneficiaries would not share in the cost of catastrophic benefits. Again, under this option benefits not related to part A would be financed by payroll taxes for the first time.

As an alternative to increasing the hospital insurance tax rate, an additional payroll tax could be instituted at a rate that would produce revenues equal to the amounts discussed under the three options above. The revenues could be placed in a trust fund specifically for catastrophic benefits.

Raising the Hospital Insurance Wage Base or Applying It to All State and Local Employees or Both

There are two additional ways to increase revenues from the hospital insurance tax for use in reducing beneficiary premiums under MCCA. First, the maximum wage to which the tax applies could be increased.[8] The maximum is expected to be $50,700 in 1990. Increasing this to $60,000 and adjusting it in future years, as under current law, would raise about $560 million in fiscal year 1990, increasing to $2 billion in fiscal year 1993. Table 3 lists estimated revenues that would be raised in fiscal years 1990 and 1993 by increasing the hospital insurance wage

[8]Each year a maximum amount of earnings is established that the hospital insurance tax will be applied to. Earnings above this level are not subject to the tax. Annual adjustments to the maximum reflect changes in average annual wages in previous years.

base to various levels in 1990, and adjusting the new wage bases annually as provided under current law. The table also lists the percentage of estimated 1993 supplemental premiums represented by the revenues realized from increasing the wage base.

Table 3: Estimated Fiscal Year 1990 and 1993 Increase in Revenues From Raising the Maximum for Wages Subject to Hospital Insurance Payroll Tax

Increase 1990 wage base from 50,700 to	Increased revenues in fiscal year (Dollars in billions) 1990	1993	Percentage of fiscal year 1983 supplemental premium revenues represented
$ 60,000	$0.6	$2.0	26
75,000	1.1	3.9	51
90,000	1.4	5.0	66
100,000	1.6	5.6	74

These new revenues could be used to decrease beneficiary funding of MCCA in the same way as the options for using revenues from increasing the hospital insurance tax rate. The effect would be to transfer part of the funding responsibility from program beneficiaries to higher income workers and their employers.

Second, the hospital insurance tax could be made mandatory for all state and local government employees. The Consolidated Omnibus Budget Reconciliation Act of 1985 required application of the tax to all state and local government employees hired on or after April 1, 1986. Extending this to state and local employees hired before then would raise about $1.2 billion in fiscal year 1990, and about $1.9 billion in fiscal years 1991-94. Such a change would not, however, represent a long-term funding source because revenues would decrease over time as affected employees retire. Moreover, it would also increase somewhat the number of Medicare beneficiaries in the future and thereby would increase overall Medicare costs in the future.[9]

[9]In a staff study, Eligibility of Civil Service Annuitants, Survivors, and Employees for Medicare, GAO/HRD-83-26, Mar. 10, 1983, we reported that about 81 percent of retired federal employees become eligible for Medicare at age 65 because of earnings in other employment or because of their spouses' earnings records. Thus, applying the hospital insurance tax to federal employees, as was done effective January 1, 1983, would make an additional 20 percent of them eligible for Medicare. We would expect a similar pattern for state and local employees.

Use General Revenues to Fund All or Part of MCCA Costs

General revenues could be raised to fund all or part of MCCA. General revenue sources that have been mentioned include alcohol and tobacco taxes and eliminating the "income tax bubble."[10] The Joint Committee on Taxation estimates that doubling the tax on a pack of cigarettes to 32 cents would raise $2.9 billion in 1990. Because of the downward trend in the number of smokers, revenues would tend to decrease over time. The Joint Committee's estimate for 1994 is $2.7 billion. Increasing the tax on beer and wine to the rate per volume of alcohol for hard liquor is estimated to raise $4.7 billion in 1990 increasing to $5.0 billion in 1994. Eliminating the income tax bubble (but retaining a 28-percent cap on capital gains) would raise $3.3 billion in 1990, increasing to $9.6 billion in 1994.

The estimates cited above indicate that alcohol and tobacco tax increases would not keep up with the rate of growth in the cost of MCCA benefits and, thus, we consider them to be only short-term funding sources. Additional revenue sources would have to be found after a few years. Elimination of the income tax bubble should tend to result in an increasing revenue stream as the incomes of those subject to the higher tax rate increase.

Currently, regular part B benefits are funded 25 percent by beneficiary premiums and 75 percent by general revenues.[11] If the Congress decides to fund the enhancements to part B benefits in the same ratio, about $3.7 billion in new general revenues would be needed in 1993. This amount could be raised through various combinations of the tax changes. Supplemental premiums could be cut in half or about 90 percent of the catastrophic coverage and drug premiums could be eliminated under this option.

To pay for 75 percent of part B catastrophic benefits and drug benefits using general revenues, about $7.5 billion would need to be raised in 1993. This amount would enable virtual elimination of supplemental

[10]Under current law, some of the revenue otherwise forgone under the Tax Reform Act of 1986 is recaptured from higher income people by increasing the marginal income tax rate for them from 28 to 33 percent above certain income levels. Once recapture is complete, the rate for additional income reverts to 28 percent. The income ranges where the 33-percent rate applies are referred to as the bubble. If the tax rate did not revert to 28 percent, this would eliminate the bubble.

[11]The percent of part B costs covered by beneficiary premiums has been set at 25 percent for the years 1983 through 1989. This percentage probably will decrease because premium increases after 1989 will be limited to the percentage increase in retirement benefits under title II of the Social Security Act and part B cost increases have historically exceeded this percentage. Our discussion of part B catastrophic funding assumes the 25-percent beneficiary share will be extended. If this is not the case, additional general revenues would be needed for options using the 25/75 funding split.

premiums or elimination of the catastrophic coverage and drug premiums and reduction of supplemental premiums by about 45 percent.

Funding 75 percent of all MCCA benefits through general revenues would require raising $9.4 billion in 1993. This would enable reducing beneficiary funding of MCCA by 75 percent.

Fund Parts A and B Enhanced Benefits Like Regular Benefits and Drug Benefits From Beneficiaries

Another option is to fund enhanced benefits in the same manner as regular benefits and new benefits entirely from beneficiaries. This would entail (1) increasing the hospital insurance payroll tax to 1.50 percent to fund the enhanced part A benefits, (2) substituting a $3.00 per month increase in the part B premium for the $7.18 catastrophic coverage premium scheduled for 1993 to fund 25 percent of the enhanced part B benefits, (3) raising $3.8 billion in general revenues to fund the other 75 percent, and (4) obtaining $5 billion from beneficiaries through the supplemental premium or drug premiums or both. Fully funding drug benefits with supplemental premiums would still permit a one-third reduction in these premiums in 1993.

The issue of maintaining an adequate revenue stream to fund increases in catastrophic costs over time mentioned under previously discussed options would also apply here. The taxpayer subsidy rate for part B would remain constant at 75 percent but the dollar value of the subsidy would increase by about $110 per beneficiary in 1993.

Reducing Benefits to Reduce Beneficiary Funding

Rather than using alternative revenue sources to enable reduction of beneficiary funding of MCCA benefits, the benefits provided under the act could be reduced to achieve this purpose. The result would be that benefit reductions would produce lower costs, which in turn would permit raising less revenue from beneficiaries while still fully funding the smaller program. A number of these options are summarized in table I.2.

Repealing or Modifying Enhanced Part A Benefits

Repealing all of the enhanced part A benefits would decrease 1993 MCCA costs by about 20 percent and permit reducing beneficiary or supplemental premiums or both by about $2.4 billion. Repeal would again expose beneficiaries with long hospital or skilled nursing facility stays to large out-of-pocket expenses of $20,000 or more in a year.

Reinstituting multiple inpatient hospital deductibles for multiple spells of illness in a year would reduce MCCA costs by about $750 million in

1993, or about 6 percent. According to Health Care Financing Administration (HCFA) data, about 1 million beneficiaries would pay multiple deductibles. Reimposing coinsurance on hospital stays over 60 days would reduce MCCA costs by about $880 million (or 7 percent) in 1993. Repealing any of the other enhanced part A benefits would result in savings of $500 million or less in 1993.

Repealing or Modifying Enhanced Part B Benefits

Repealing all enhanced part B benefits would result in MCCA costs being reduced by $4.9 billion, or about 39 percent, in 1993. Most costs of the enhanced benefits are related to the cap on beneficiary cost sharing—$4.3 billion in 1993. Repeal of the respite care benefit—$420 million—and the screening mammography benefit—$150 million—would reduce MCCA costs by 5 percent.

Rather than outright repeal of the beneficiary cost-sharing cap, the amount of the cap could be increased so that fewer beneficiaries reach it and MCCA costs are reduced. However, because current law is designed to result in 7 percent of beneficiaries receiving enhanced benefit payments after exceeding the cap, incremental increases in the amount of the cap would result in relatively small reductions in Medicare costs. For example, increasing the cap from $1,370 to $1,500 in 1990 could be expected to reduce costs by only about $400 million, or 3 percent, by 1993. An increase in the 1990 cap to $1,700 could reduce MCCA costs by about $1 billion, or 6 percent, in 1993.

To affect more beneficiaries, and therefore reduce Medicare costs by larger amounts, the part B deductible could be raised. More beneficiaries would receive no payments under part B but the same number would benefit from the cap. Increasing the deductible by $25 to $100 would yield reduced Medicare costs of about $600 million in 1993. About 25 million beneficiaries would have increased out-of-pocket costs. An additional 5 million beneficiaries would not receive any part B payments because their total covered expenses would not exceed the increased deductible. Doubling the deductible to $150 would reduce costs by $1.5 billion in 1993. A $200 part B deductible would reduce Medicare costs by about $2 billion in 1993.

Repealing or Modifying MCCA Drug Benefits

The main new service coverage benefit provided by MCCA is the one for outpatient prescription drugs and it represents about 40 percent of MCCA's estimated costs in 1993. Repealing the benefit, which is expected

to help 5.9 million beneficiaries, would reduce costs by about $5 billion in that year.

One alternative to outright repeal would be to decrease the number of people obtaining payments under the drug benefit by increasing the drug deductible. Under current law, 16.8 percent of beneficiaries will receive payments in 1993. If this were decreased to 10 percent, MCCA costs would be reduced by about $1.9 billion. Another alternative would be to increase the coinsurance that beneficiaries are liable for after meeting the drug deductible. Increasing the coinsurance rate from 20 to 30 percent would reduce costs by about $550 million in 1993. An increase to 40 percent would yield reduced costs of about $1 billion and to 50 percent of about $1.6 billion. The same number of people would benefit as under current law but their out-of-pocket drug costs would be higher.

Redistributing MCCA Funding Among Beneficiaries

To reduce the amount of supplemental premiums while retaining the same benefit package under MCCA, its funding could be redistributed among beneficiaries. Several options are summarized in table I.3.

The supplemental premium is estimated to raise about $7.6 billion in 1993. For every $1 billion supplemental premiums are reduced, catastrophic coverage or drug premiums or both would need to be increased by $2.50 per month to maintain revenues. Cutting in half the maximum amount of supplemental premium an individual can be liable for (e.g., from $1,050 to $525 in 1993) would reduce revenues by about $2.4 billion, which could be offset by increasing other premiums by about $6 per month. Cutting in half the supplemental premium rate per $150 of income tax liability would reduce revenues by $2.7 billion, which would require a $6.70 per month increase in other premiums.

Changes like those discussed above would result in a more regressive funding scheme than current law because a higher portion of revenues would be raised from lower income beneficiaries. The lowest income beneficiaries would be protected, however, because another provision of MCCA (section 301) requires that no later than January 1, 1993, state Medicaid programs must pay Medicare premiums,[12] deductibles, and coinsurance for individuals with incomes at or below the poverty level. Because the federal government pays on average 55 percent of state

[12]Medicaid is a means-tested program under which the federal government shares in state costs of health care services received by cash welfare recipients and other low income persons.

Medicaid costs, increasing premiums, deductibles, or coinsurance would have the effect of increasing the need for general revenues but we did not estimate the amount involved.

Another possible option would be to repeal the MCCA drug benefits and protect lower income beneficiaries from drug costs by amending section 301 to require states to include Medicaid drug coverage along with coverage of beneficiary cost sharing. The drug premium would be eliminated and supplemental premiums could be reduced by half. Medicare beneficiaries whose incomes are too high to qualify for full Medicaid coverage but below the poverty line would have their drug costs covered. The income threshold could also be modified to cover a larger portion of Medicare beneficiaries; for example, beneficiaries with incomes below 150 percent of the poverty line could be provided Medicaid drug coverage.

Medicaid drug coverage for low-income Medicare beneficiaries would require additional revenues for both the federal and state governments but sufficient data was not readily available for us to estimate the amount required. One disadvantage to this approach is that drug coverage under Medicaid is not uniform from state to state and two states do not cover drugs. Thus, the extent of drug coverage available would depend on where a beneficiary resides.

Combinations of New Revenues, Benefit Cuts, or Redistribution of Funding

Many of the features of the options discussed above could be used in combination to reach a given goal. For example, if the goal were to enable cutting the supplemental premium rate in half, many combinations of new revenues, benefit cuts, or other premium increases would offset the revenue forgone by reducing the rate—about $2.7 billion in 1993. Two possible combinations are:

- Covering enhanced part A benefits by an increase of 0.05 percentage point in the Social Security payroll tax (new revenues of $2.7 billion) and increasing the part B deductible by $15 (Medicare savings of $400 million) would produce the needed amount in 1993 with a small cushion.
- An increase of $2 per month in the catastrophic coverage premium (redistribution among beneficiaries of $800 million), setting the beneficiary cost-sharing cap at $1,700 in 1990 (MCCA savings of $1 billion), and a 6-cents per pack increase in the cigarette tax ($1 billion in new revenue) would also offset the 1993 revenue loss from such a cut in the supplemental rate.

Repealing or Phasing Out MCCA

One way to reduce the need to raise funds from beneficiaries is to repeal or phase out the Medicare catastrophic program. This would reduce out-of-pocket costs for beneficiaries who have Medicare supplement (Medigap) policies partly or fully paid for by their former employers.[13] Beneficiaries purchasing Medigap policies themselves would tend to have increased out-of-pocket costs because Medicare administrative costs are normally much lower than administrative costs and profits on Medigap policies.[14] Medicaid costs could also increase because Medicaid would pay for costs that Medicare would have paid for low-income beneficiaries also eligible for Medicare. In addition, out-of-pocket costs would increase for beneficiaries not poor enough to qualify for Medicaid who do not have employer subsidized Medicap policies.

If MCCA were repealed or phased out and the Congress wanted to provide similar protection to lower income beneficiaries, it could amend the Medicaid program to require states to pay premiums, deductibles, and coinsurance for additional beneficiaries. For example, all Medicare beneficiaries with incomes below 150 percent of the poverty level could be provided Medicaid coverage for their Medicare cost-sharing liabilities. Lower income beneficiaries would be protected from catastrophic costs associated with regular Medicare benefits but would lose coverage for the new benefits in MCCA, in particular those for prescription drugs. As discussed on page 14, the Congress could also require states to cover prescription drugs for low-income beneficiaries. Again, drug benefits would not be uniform from state to state. If the Congress were to require states to cover Medicare cost-sharing or prescription drugs or both for additional beneficiaries, this would increase Medicaid costs and necessitate increased general revenues for both the federal and state governments.

A complicating factor for the Congress related to repealing or phasing out MCCA is that such action could increase the federal deficit for Gramm-Rudman-Hollings deficit reduction purposes. In designing MCCA the Congress decided to build a contingency reserve during the early years of the program. Thus, the revenues resulting from MCCA are expected to exceed program costs in fiscal years 1990 and 1991, and eliminating these revenues would result in a larger deficit in those years.

[13]Medigap policies available to individuals do not generally cover drugs but we do not have information on the extent of drug coverage under employer-sponsored Medigap policies. To the extent these plans do not cover drugs, beneficiaries would lose an important benefit provided by MCCA.

[14]See Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 17, 1986), and Medigap Insurance: Effect of the Catastrophic Coverage Act of 1988 on Benefits and Premiums (GAO/T-HRD-89-13, Apr. 6, 1989).

For fiscal year 1990, MCCA revenues are expected to exceed costs by $4.2 billion and for fiscal year 1991 by $2 billion.

Another complicating factor related to repealing or phasing out MCCA is that if section 301 (which requires Medicaid coverage of low-income Medicare beneficiary cost sharing) is not also repealed, Medicaid costs will increase because it will be paying for cost-sharing items that would not exist with MCCA. For example, low-income Medicare beneficiaries would again be liable for coinsurance on long hospital stays and for part B coinsurance for services above the level that would have triggered MCCA's cost-sharing cap. We did not estimate the additional federal (or state) Medicaid funds that would be required if MCCA was repealed without repealing section 301. Of course, repealing section 301 would again expose low-income Medicare beneficiaries who do not qualify for Medicaid to catastrophic out-of-pocket costs.

Making MCCA Coverage Optional

The Committee's office asked us to consider the effects of making coverage under MCCA optional for beneficiaries. We considered two different versions of optional coverage. The first is to allow beneficiaries to choose coverage under MCCA and to prohibit them from participating in part B if they decline MCCA. Because of the large 75 percent taxpayer subsidy of regular part B benefits, we would expect few beneficiaries would choose not to be covered by MCCA. Purchasing private health insurance without the benefit of the taxpayer subsidy would typically be significantly more expensive than the maximum a beneficiary would pay under MCCA. To our knowledge, the only major group of persons 65 years old or older that would be eligible for comprehensive employer-sponsored private health insurance is retired federal employees because other employers only offer Medigap policies to persons who could be or are covered by Medicare.

Alternatively, if beneficiaries were allowed to decline coverage under MCCA but retain regular part B, we would expect a much larger number of beneficiaries to decline MCCA. Those beneficiaries with Medigap policies paid in whole or in part by their former employers would probably have lower out-of-pocket costs by declining coverage, especially because we expect that these beneficiaries would tend to be the ones with higher incomes and thus subject to supplemental premiums. Therefore, revenues resulting from MCCA would probably decline much more than program costs. And premiums for beneficiaries electing coverage under MCCA would have to be raised substantially or other revenues generated through increased taxes on the general public or both.

Part A Costs for Enhanced Skilled Nursing Facility Benefits May Be Higher Than Estimated

Recent HCFA data indicate that Medicare costs for skilled nursing facility services increased rapidly in the first part of 1989. The extent to which the increase was due to enhanced MCCA benefits or to other factors is not clear.

We have received anecdotal information that one of the reasons that Medicare costs increased was that states were using the enhanced MCCA benefits to reduce their Medicaid expenses by transferring Medicaid/Medicare dual beneficiaries to Medicare certified beds. By doing this, Medicare would pay for the care for up to 150 days, relieving Medicaid of the cost. HCFA data indicates that this could be part of the cause of the increased Medicare costs. Medicare skilled nursing home admission notices increased dramatically in January 1989 when this benefit was effective to about 105,000 from a rate in the mid-40,000's during the preceding 6 months. Admission notices dropped to about 64,600 and about 67,100 for February and March 1989.

We do not believe it was the Congress' intention to shift funding of a portion of Medicaid skilled nursing facility costs from general revenues to Medicare beneficiary premiums. Thus, regardless of any other actions taken with respect to MCCA, we believe it would be reasonable to fund from nonbeneficiary sources any Medicare cost increases resulting from increased Medicaid beneficiary use of the enhanced skilled nursing facility benefits of MCCA.

CBO and HCFA are both looking at the implications for MCCA cost estimates of the unexpected increase in Medicare costs for skilled nursing facilities.

Objectives, Scope, and Methodology

As requested, our objective was to identify options for restructuring benefits and financing under MCCA, including repealing or phasing out the program.

We reviewed title XVIII of the Social Security Act as in effect before MCCA and MCCA itself to identify the benefits and financing of each. We discussed with and obtained information from HCFA and CBO officials about their estimates of the costs and revenues associated with MCCA. We also obtained information from the Joint Committee on Taxation and CBO related to changing various tax rates, such as those on cigarettes

and alcohol, and revising the hospital insurance tax. Using the information obtained and our knowledge of the Medicare program and its interrelationships with the Medicaid program, we formulated various options for MCCA.

The estimates of the fiscal consequences of and number of beneficiaries affected by each option presented are based on the best data available at the time this report was prepared. These estimates are based on CBO and other estimates and are subject to change.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 5 days after its issue date. At that time, we will send copies to interested congressional committees, the Secretary of Health and Human Services, and to other interested parties. We will make copies available to others on request. Major contributors to this report are listed in appendix II.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Selected Options for Modifying Medicare Catastrophic Act Financing and Benefits

Table I.1: Some Alternative Sources of Financing

Dollars in billions

Option	1993 Revenue	Effects on need for beneficiary funding
Hospital insurance (HI) tax		
Increase HI tax rate to 1.50 percent to cover part A benefits.	$2.7	Reduce supplemental premium by 33% or reduce flat premium by 65%.
Increase HI tax rate to 1.60 percent to cover parts A and B benefits.	8.0	Eliminate supplemental premium or eliminate flat premium and reduce supplemental premium by 50%.
Increase HI tax rate to 1.70 percent to cover all MCCA costs.	13.3	Eliminate beneficiary funding.
Raise 1990 HI tax wage base from $50,700 to $75,000.	3.9	Reduce supplemental premium by 50% or reduce flat premium by 95%.
Raise 1990 HI tax wage base to $100,000.	5.6	Reduce supplemental premium by 75% or eliminate flat premium and reduce supplemental premium by 20%.
Other taxes		
Double cigarette tax.	2.9	Reduce supplemental premium by 40% or reduce flat premium by 70%.
Increase tax on beer and wine to hard liquor rate.	4.9	Reduce supplemental premium by 65% or eliminate flat premium and reduce supplemental premium by 10%.
Eliminate income tax "bubble."	8.4	Eliminate supplemental premium and reduce flat premium by 20% or eliminate flat premium and reduce supplemental premium by 55%.
General revenues		
Fund 75% of part B enhancements with general revenues.	3.7	Reduce supplemental premium by 50% or reduce flat premium by 90%.
Fund 75% of part B enhancements and drug benefits from general revenue.	7.5	Eliminate supplemental premium or eliminate flat premium and reduce supplemental premium by 45%.
Fund 75% of all catastrophic benefits from general revenues.	9.4	Eliminate supplemental premium and reduce flat premium by 45% or eliminate flat premium and reduce supplemental premium by 70%.
Example of funding through multiple financing sources		
Fund parts A and B enhanced benefits like regular benefits and drug benefits from beneficiaries by		Reduce catastrophic coverage premium by 58% and reduce supplemental premium by 35%
1) increasing HI tax to 1.50 percent,	2.7	
2) reducing flat premium to $3.00,	1.2	

(continued)

Option	1993 Revenue	Effects on need for beneficiary funding
3) raising $3.7 billion in general revenues, and	3.8	
4) funding drug benefits from beneficiaries.	5.0	

[a]The flat premium is composed of the catastrophic coverage and drug premiums which are paid by all part B beneficiaries.

Table I.2: Reducing Benefits to Reduce Beneficiary Spending

Dollars in billions

Option	1993 savings	Effects on beneficiary funding
Part A benefits		
Repeal enhanced part A benefits.	$2.4	Reduce supplemental premium by 30% or reduce flat premium[a] by 60%.
Reinstitute multiple inpatient hospital deductibles for multiple spells of illness in a year.	0.75	Reduce supplemental premium by 10% or reduce flat premium by 20%.
Reimpose coinsurance for hospital stays over 60 days.	0.88	Reduce supplemental premium by 10% or reduce flat premium by 20%.
Part B benefits		
Repeal enhanced part B benefits.	4.9	Reduce supplemental premiums by 65% or eliminate flat premium and reduce supplemental premium by 10%.
Repeal cap on beneficiary cost sharing.	4.3	Reduce supplemental premium by 55% or eliminate flat premium.
Increase 1990 cap to $1700.	1.0	Reduce supplemental premium by 15% or reduce flat premium by 25%.
Increase part B deductible to $150.	1.5	Reduce supplemental premium by 20% or reduce flat premium by 35%.
Drug benefits		
Repeal drug benefit.	5.0	Reduce supplemental premium by 65% or eliminate flat premium and reduce supplemental premium by 10%.
Decrease percentage of beneficiaries receiving payment under drug benefit from 16.8 to 10%.	1.9	Reduce supplemental premium by 25% or reduce flat premium by 45%.

[a]The flat premium is composed of the catastrophic coverage and drug premiums which are paid by all part B beneficiaries.

Table I.3: Redistributing Catastrophic Funding Among Beneficiaries

Dollars in billions

Option	Amount shifted in 1993	Would require
Reduce supplemental premium payment cap by one-half.	$2.4	Increase flat premium[a] by 60% ($6.00 per month).
Reduce supplemental premium rate per $150 of income tax for liability (from $42.00 to $21.00 in 1993).	2.7	Increase flat premium by 65% ($6.70 per month).

[a]The flat premium is composed of the catastrophic coverage and drug premiums which are paid by all beneficiaries.

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